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WHITE PAPER

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SETTING THE STANDARD FOR EXCELLENCE IN REVENUE CYCLE MANAGEMENT

Prepare your hospital for a new level of specificity

New MS-DRGs add increased demands for HIM/coding, clinical documentation staff

On October 1, 2007, CMS made its most significant change to the DRG system since its 1983 inception when it finalized Medicare Severity DRGs (MS-DRGs). Coupled with the new system, CMS also passed a corresponding "documentation and coding adjustment," or phased-in payment cut.

In a press release accompanying the IPPS final rule, CMS Acting Deputy Administrator Herb Kuhn stated that Medicare payments for inpatient services "will be more accurate and better reflect the severity of the patient's condition."

CMS said it adopted MS-DRGs to prevent abuses under the current CMS-DRG system. "Under the old DRG system (with payments based on broad averages) incentives could lead hospitals to 'cherry pick'—the practice of treating only the healthiest and most profitable patients," CMS said in the release. However, the replacement of the CMS-DRG system with MS-DRGs means that times are changing for HIM/coding staff and clinical documentation improvement (CDI) specialists.

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"The bottom line with the new system is that CMS is looking for specificity—[CDI specialists or HIM/coding staff] will have to go into further specificity of the diagnosis codes," says **William Haik, MD**, director of DRG Review, Inc., in Fort Walton Beach, FL. "The documentation has to support the coding, and the only way that can happen is for doctors to specify the diagnosis. This means that documentation specialists either must educate the attending physician, query the physician, or both."

An overview of MS-DRGs

The rule creates 745 new MS-DRGs to replace the current 538 DRGs. It also differentiates the familiar complication/comorbidity (CC) classification to CCs and major CCs (MCC), which are conditions that require double the additional resources of a normal CC.

Here's an example of how the new system works:

Under the current CMS-DRG system, congestive heart failure (CHF) unspecified—ICD-9-CM code 428.0—is a complication/comorbidity (CC), and if a physician documents it in the record, and a coder assigns it, it affects the DRG assignment.

But under the new system, CHF unspecified (428.0) is not a CC. However, if the physician further specifies CHF as either diastolic (428.30) or systolic (428.20) in nature, it is a CC. Further, if a physician specifies CHF as acute diastolic (428.31) or acute systolic (428.21) in nature, it qualifies as a major CC. But the catch is that physicians must get very precise with their documentation.

"Those words have to be in the chart—diastolic or systolic congestive heart failure, and acute—to toggle you up to a CC or a major CC," Haik says. "You can see that that level of specificity makes an enormous difference in the potential on DRG impact."

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Because a coder or CDI specialist might have to ask as many as two or three questions of a physician to arrive at the right diagnosis, the value of a real-time documentation improvement program cannot be overestimated, Haik says. "That's why it's important to do these queries concurrently, while the patient is still in-house," he says. "This makes the concurrent documentation specialist even more valuable."

Some good news with MS-DRGs

The good news with the new MS-DRG system, says **James S. Kennedy, MD, CCS**, director with FTI Healthcare in Brentwood, TN, is that coders will still report ICD-9-CM codes using the same principal/secondary diagnosis and procedure coding conventions as before. That means the "working DRGs" CDI specialists often assign as part of their role will remain largely the same. "The base DRGs, for all practical purposes, remain the same, although they'll have different numbers and there's some consolidation," says Kennedy.

"This shouldn't necessarily change the way coders assign codes, but they will have to be more cognizant of capturing every CC and more specific diagnoses," adds **Shannon McCall, RHIA, CCS, CPC**, director of health information management/coding for HCPro, Inc., in Marblehead, MA.

Just like under the old system, it still takes only one CC or one MCC to change a DRG. CDI specialists and coders will be pleased to find that CMS restored five CCs and four MCCs that were previously deleted, including acute blood loss anemia (285.1) and trifascicular block (426.54), among others. Also, coma (780.01) is now an MCC.

"I do think on a more positive note, [MS-DRGs] will positively affect those hospitals that do have a more severe case mix index," says McCall. "But this could cause problems for physicians because it will require them to give coders even more specific information than they do now."

And some bad news with MS-DRGs

The bad news is that CMS is implementing a corresponding payment cut over a three-year period. While subsequent legislation reduced the cut, hospitals still face the following reductions in their overall IPPS reimbursement:

- 0.6% for fiscal year (FY) 2008
- 0.9% for FY 2009
- 1.8% for FY 2010

These reductions are to offset the improved documentation and coding—and therefore, payment—CMS believes providers will adopt, based on past data.

In other bad news, Kennedy says that revisions to the CC/MCC table will result in fewer MS-DRGs reported with a CC: 41.1% of MS-DRGs providers report will be without a CC, whereas providers today only report 22.34% of CMS-DRGs without CCs. Of the remaining 58.8% that will be CC/MCCs under MS-DRGs, 22.2% will be MCCs and 36.6% will be CCs.

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Kennedy also says that CMS did not correct some of its logic errors in CC/MCC designation—errors that will ultimately reward nonspecific physician documentation. For example, CMS classified malnutrition, not otherwise specified, as a CC, whereas mild/moderate malnutrition is not a CC. "It pays for hospitals to not be specific with malnutrition, which I think is wrong," he says. Also, CMS did not differentiate between sepsis and severe sepsis—it classifies both as MCCs.

"Another problem for HIM departments could be increased accounts receivable while coders wait for physician responses to outstanding queries," adds **Deborah Mange, RN, BSN,** DRG-DOC specialist in the documentation improvement program at EMH Regional Medical Center in Elyria, OH.

Potential MS-DRGs stumbling blocks

Providers can expect four hurdles, in particular, as they prepare for the MS-DRG system:

1. Coding professionals will need to learn a completely new CC system. CMS eliminated a large number of chronic conditions that it deemed to have little impact on resource utilization. Now with two tiers of CCs (i.e., regular CCs and MCCs), an increased number of records will require review or re-review to ascertain that the correct CC or MCC has been captured, Kennedy says.

"I think the biggest challenge is going to be capturing the CCs and MCCs in light of the fact that, now, many of the nonspecific or chronic conditions have been moved off the CC list—the most common being congestive heart failure [CHF]," says **Kimberly Anderwood Hoy, JD, CPC,** director of Medicare and compliance for HCPro, Inc., in Marblehead, MA. "The challenge is capturing the specificity that's needed to get CCs."

"Another challenge is learning to recognize the CC's that have been added that coders may not be used to picking up, like body mass index [BMI] , and making sure when they code diagnoses that were not a CC before, that they look for and code the specificity that becomes a CC," Mange says. "For example, bipolar, unspecified (296.80), vs. bipolar, other (296.89), and using the combination code for a patient with dementia and depression (290.21)."

2. Coders will have to apply the present-on-admission (POA) indicator. The physician documentation needs to be clear about POA conditions, and coders should have the clinical knowledge to be able to look at a chart and identify possible POA conditions, so they know when it's appropriate to query physicians for this information. For example, pressure sores and catheter-related urinary tract infections will eventually not be allowed as CCs if they are not POA.

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POA reporting also went into effect October 1, and the payment adjustment will start October 1, 2008. "Coders will have to be much more clinically astute to be able to surmise what should have been POA," Kennedy says. "Coders should code with the concept in mind: 'How would a recovery audit contractor [CMS contractors who examine hospital inpatient and outpatient claims for over and under-coding] code this record?' That holds you to a very high level of documentation for coding."

3. Hospitals need to establish, if they haven't already, clinical documentation improvement programs. Facilities that don't have a program in place that engages physicians and urges them to accurately document illness severity using ICD-9-CM language will find that their case mix index will drop under MS-DRGs, reducing the financial support necessary to carry out their mission, says Kennedy.

"A hospital has to communicate what [kind of documentation it] needs. It has to have systems in place to capture the CCs and MCCs, and there has to be consequences for noncompliance," he says. "The hospital has to [convey to its staff members] that they need a complete history and physical [H&P] on patients they admit."

"They also need to respond in a timely manner to all concurrent and retrospective queries to provide that accurate clinical picture that benefits both the physician and the hospital," adds Mange.

4. Coders will feel pressure to make up the financial deficit. Rural hospitals are expected to lose 1.1%–2.7% of their revenue—before the documentation and coding adjustment—whereas urban teaching and disproportionate share hospitals will see a 0.5% revenue increase as a result. "Not only will coding staff have to dig deeper and query more often to find a CC, they will have to go the extra mile to capture an appropriate MCC," says Kennedy. Facing the temptation to make up for the loss, coders will have to work diligently to ensure that the records are ethically and professionally coded, in case of future scrutiny, Kennedy adds.

Get your program up to date

The bottom line is that hospitals that do not have a CDI program—one that engages medical and coding staff to co-operatively document and report illness severity using ICD-9-CM terminology—should strongly consider implementing one now, Kennedy says. "Given the documentation and coding adjustment, and the complete revision of the CC/MCC structure, hospitals that don't implement such a clinical documentation program will be left behind," he says.

"Coders and CDIs need to be very knowledgeable about what to look for, how and when to query, how to motivate the physicians to document for specificity, and how to code the chart accurately in light of the new changes."

Mange says that the initial learning curve is large, and that educating coders and physicians is essential. "Physicians are not always willing to change quickly," she says. "Coders and CDIs need to be very knowledgeable about what to look for, how and when to query, how to motivate the physicians to document for specificity, and how to code the chart accurately in light of the new changes."

If your hospital already has a CDI program, the next step is to get physicians up to speed about their new requirements under MS-DRGs. This will prove to be a difficult challenge, Haik says, especially if you ask physicians to just "document better."

"When clinical elements in the medical record suggest a more specified diagnosis, such as aspiration pneumonia, the documentation specialists may query the attending physician for further specificity," Haik says. "However, the physician may answer nonspecifically, with comments such as "really severe pneumonia."

Haik says that clinical documentation specialists, be they from nursing, coding, or case management backgrounds, will have to:

- Schedule large meetings with physicians to provide education regarding the new system
- Break down the documentation requirements of individual service lines (e.g., cardiology, pulmonary, gastrointestinal) and educate physicians in department-specific sessions
- Teach by means of osmosis—pose queries to physicians every day about clinical elements until they are familiar with the new requirements

MS-DRGs top 10 readiness checklist

To ensure that your hospital is taking the appropriate steps to manage the new MS-DRG system, follow this top 10 checklist of readiness action items:

1. **Know your CCs and MCCs.** The old list of complications and comorbidities (CCs) has changed under MS-DRGs, and major complication/comorbidity (MCC) is a new term with which you should become intimately familiar.
2. **Update your query forms.** Make sure your forms are updated and are focused on capturing severity of illness.
3. **Ensure your grouper is updated**. Check with your vendor to ensure that your DRG grouper is updated.
4. **Perform coding education**. Educate your HIM/coding staff about the new system and its coding requirements, including present on admission reporting.
5. **Perform physician education**. Just as important as HIM/coding, educate your physician staff about MS-DRGs and prepare them for increased querying.
6. **Alert financial staff**. Hospitals will experience a financial impact under MS-DRGs, and you should alert finance of possible positive/negative variances.
7. **Consider a clinical documentation improvement program**. These are nurses, case managers, or HIM/coding staff with strong clinical backgrounds that review inpatient charts concurrently, and query physicians in real-time.
8. **Implement a concurrent coding program**. If you can't implement a full CDI program, require HIM/coding to post concurrent queries. Don't wait until the patient is discharged.
9. **Check your data against CMS' benchmarks.** CMS anticipates a typical MCC capture rate of 22.2%, a CC capture rate of 36.6%, and that 41.1% of diagnoses reported will not have a CC or an MCC.
10. **Watch for productivity declines.** Studies have shown that coders could experience a 20-30% decline in productivity after October 1. This may require additional temporary or full-time staff.

"The only time that physicians will learn—and that goes for everyone else in this world—is they have to understand, when it comes to code reporting and chart documentation, that their skins are in the fire," he says.

"A CDI program using a diversity of methods to get the word out to coders and physicians is essential," Mange adds. ■

Editor's note: To read more about MS-DRGs, go the CMS Web site: http://www.cms.hhs.gov/AcuteInpatientPPS/, *and click on "IPPS regulations and notices."*

If you have a question about MS-DRGs, send an email to revenuecyclemanagement@hcpro.com.